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ORIGINAL ARTICLES

Individual Barriers to Implementation of Whole Health for Pain Management Among Veterans

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Abstract

This commentary addresses individual barriers to implementation of a Whole Health approach to pain management that included a group pain education session and individual therapy. The authors identify individual barriers to veteran participation in the Whole Health program and also make recommendations for future programs. One of the most intriguing identified barriers to participation was the concern about the veteran's readiness for change that would facilitate active engagement in the program.

Keywords: whole health, pain management, barriers

Patient engagement is one of the most challenging components of implementing new and innovative programs, especially those utilizing alternative approaches. This commentary will discuss the challenges associated with enrolling veterans into a pilot program utilizing a Whole Health approach to managing chronic pain. Led by the VA Office of Patient-Centered Care and Cultural Transformation (OPCC&CT), the Veterans Affairs (VA) has been undergoing a transformation from a medical/disease-based system of care to a health care system that addresses the whole patient, encompassing a management strategy that acknowledges the patient's values and priorities.[1]

With the Whole Health approach, when the veteran presents to the provider, the focus is to address the chief complaint in the greater context of the veteran's life. The Whole Health approach to managing chronic pain is especially important in the context of the current opioid crisis in veterans[2] and the association of chronic pain and suicide.[3]

Previous study performed through the OPCC&CT has focused on organizational level barriers to implementation of the Whole Health approach.[1,4] This commentary focuses on the challenges associated with enrolling veterans in a novel approach to pain management that utilized pain education (group session) and optional individual coaching to help engage the veteran in self-management at a rural Level III VA medical center. This project identified significant individual barriers to implementation of a Whole Health program for chronic pain, some of which surprised the authors. Although the authors identified a number of logistical and social barriers to veteran engagement, they do not believe these fully explained the remarkably low enrollment numbers; the explanation for this phenomenon may require further evaluation of the veteran's readiness to change.[5]

Recruitment and Follow-Through Process

Given the incidence of chronic pain in veterans and the current focus on nonpharmacologic strategies to address pain,[6,7] the authors sought to evaluate a program that would utilize a combination of pain education, through a Whole Health for Pain group session and also allow for the option of individualized Whole Health coaching (further described hereunder). The program was determined by the Institutional Review Board (IRB) in Syracuse NY to be a program evaluation, therefore did not require IRB review or approval.

The authors initially sought to examine the effectiveness of the Whole Health approach to pain management through a small-scale (local level) program evaluation. The initial recruitment plan included identifying all veterans at the Finger Lakes Healthcare System who had an active opioid prescription. The authors used broad inclusion criteria due to the pragmatic nature of the project, the only exclusion criteria were unwillingness or inability to participate in the program. They then contacted the identified veterans through a recruitment letter and follow-up phone calls. Contact with the veterans was

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carried out by two experienced PhD level study coordinators who were temporarily funded for this project through a small grant from the Office of Mental Health.

Recruitment initially consisted of an introductory letter describing the program mailed to the 591 veterans currently receiving an opioid prescription (Fig. 1). A week later, staff attempted to contact these veterans by phone to answer any questions and ascertain their interest in participating. Staff explained that this program was designed for veterans with chronic pain, it employed an individualized approach to pain management, and veterans would be matched to a coach. The coach would evaluate the veteran's chronic pain history, discuss nonpharmaceutical evidence-based pain management programs, and work together with the veteran to develop a plan. The veteran could attend an orientation session (one-time general introduction in a group setting) and/or individual coaching sessions.

Those veterans who expressed interest were forwarded to a VA scheduler who would call the veteran and schedule them for Whole Health for Pain Orientation/Coaching. Those who were scheduled were provided with a reminder call the day before their appointment. The authors identified a large number of veterans who they felt would benefit from the program. However, despite initial enthusiasm during the recruitment process, they had very few who actually engaged in the program. Given the fact that only 19% of those who initially expressed interest in the program actually attended the program, the authors sought to understand barriers that both veterans and staff faced.

Identifying Engagement Barriers

Of the 121 veterans who expressed interest in attending during the phone follow-up, only 23 attended the Whole Health orientation session. Of these, only eight went on to engage in Whole Health coaching. (Of the eight participants who participated in Whole Health Coaching, all were male with a mean age of 55 years; 87.5% were Caucasian and 12.5% were African American.) This low attendance rate provided the authors with an opportunity to learn about some of the barriers regarding Whole Health for Pain implementation (Table 1). In the process of attempting to enroll veterans into this program, staff took notes on the reasons they provided for deciding to decline. The authors also met as a team to discuss difficulties staff were facing in attempting to enroll veterans.

Results and Discussion

In the process of exploring why only 19% of veterans who were interested in enrolling in Whole Health for Pain Orientation/Coaching ultimately attended the program, the authors were able to identify a few key barriers to enrollment. One of the first issues to surface was the importance of basic logistics (e.g., setting an appointment with the veteran directly after they indicated interest) and flexibility (e.g., offering the program on multiple days). Also noted was the lack of multiple clinicians to deliver the program, thus if one clinician was unavailable, the sessions had to be cancelled. Furthermore, given the number of veterans who

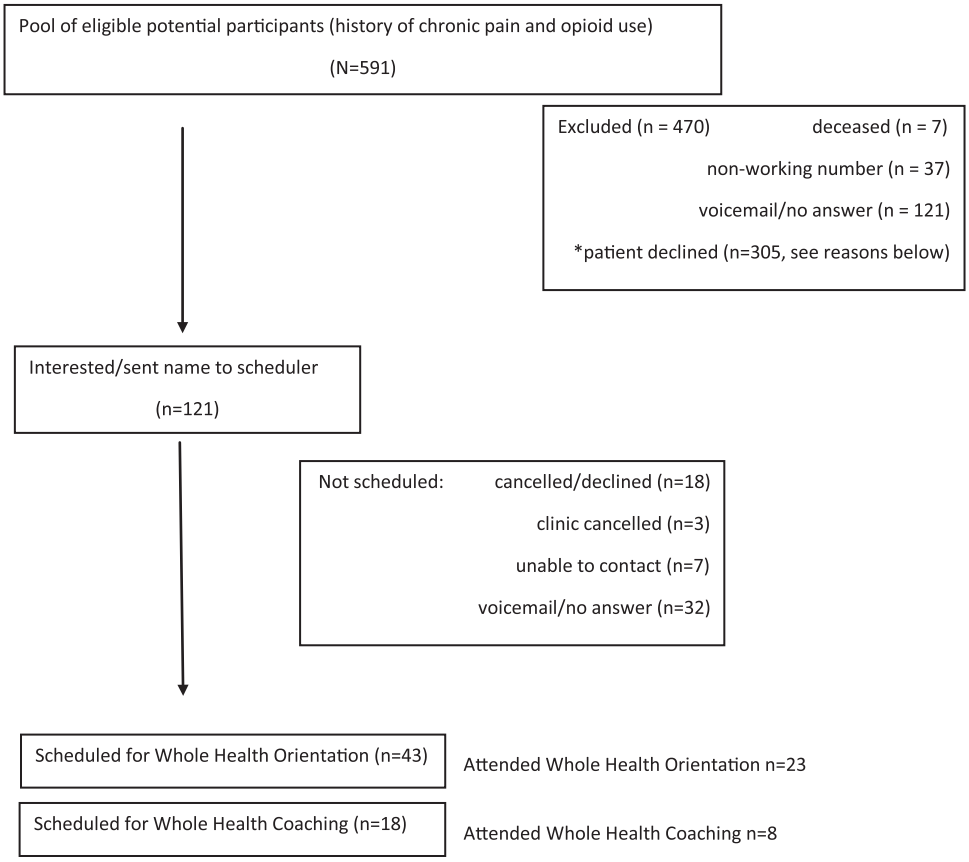

FIG. 1. Flow diagram for enrollment of participants. Pool of eligible potential participants (history of chronic pain and opioid use). Note: The eight who attended coaching also attended orientation. Notes: *Of the 305 participants, 148 provided reasons why they decided to decline, as follows: (1) ''happy with current treatment'' ($n=41$), (2) ''too busy with other things (tough getting to appointments)'' ($n=35$), (3) logistical challenges (too far/not mobile/bedridden) ($n=34$), (4) ''do not think program will work'' ($n=30$) and (5) other (dementia, tired of the VA, concerned about meds) ($n=8$). VA, Veterans Affairs.

Table 1. Barriers Leading to Low Attendance in Whole Health for Pain Management Among Contacted Veterans

	Barriers from veteran's perspectives	*Barriers from program evaluation team member's perspectives*	*Recommendations*
Logistical	Difficulty attending orientation/coaching due to: • Limited mobility, bedridden • Distance • Recent surgery • In process of moving	Scheduling lag time: After veteran indicated interest by phone, VA scheduler called back to arrange; many were lost in process Program offered 1×/week One leader meant no backup if they were unavailable	Provide streamlined referral process in one unified WH department Identify multiple coaches to accommodate multiple offerings Deliver program using multiple formats
Social	Lack of understanding of Whole Health program (e.g., some veterans stated they were not interested in any more meetings and they did not see how a class could help them; some veterans stated they were not interested in nonmedical interventions)	Overall lack of awareness of the WH program at the local facility	Identify local WH champion who can provide education to veterans and providers on potential alternatives for pain management
	Self-efficacy, or belief they had the ability to improve their pain (e.g., one veteran stated that he's been in pain for 12 years, and there is nothing we can do for him; many veterans stated that they had already tried everything to manage their pain)	Veterans exhibiting chronic pain behaviors such as catastrophizing, fear avoidance, and lack of self-efficacy present a challenge in promoting the program to veterans	Consider training providers to introduce WH pain management concepts in the course of clinical care, specifically addressing the area of self-efficacy (see Results and Discussion section)
	Suspicion this program was a fad (e.g., some veterans stated they were tired of the VA and tired of trying new programs)	Systemic change creates challenges in overall trust of the health care system thus creating doubt about sustainability of program	Improved marketing that includes examples of success from other facilities

VA, Veterans Affairs; WH, Whole Health.

declined due to mobility reasons, it also would have been helpful to offer this program using multiple platforms, including telehealth. These barriers may be addressed through a centralized Whole Health program that utilizes providers of different backgrounds and disciplines to deliver the course material through both in-person and remote formats.

The authors were surprised to learn that many more veterans were interested in attending the Whole Health for Pain Orientation than were interested in attending individual coaching sessions. It appeared that most veterans were satisfied to receive the Whole Health information without any follow-up. One of the goals of the Whole Health Initiative is for the veteran to take the lead in knowing/advocating for their own health care needs. It may be the case that many veterans who are employing the Whole Health management approach to pain do not feel the need for coaching, which involves meeting individually with the veteran to identify specific strategies for self-management and to provide follow-through with prescribed treatments.

One way to address the lack of interest in Whole Health coaching is to consider alternative delivery of the message of Whole Health such as offering self-directed online formatting of the material that would be delivered during the in-person orientation session. There has been some study on delivering an interactive pain management education in an online format that has shown some initial success.[8]

Overall, the authors learned that 22% of those eligible to participate in their sample were interested in enrolling in the Whole Health for Pain Orientation/Coaching, thus demonstrating that a substantial proportion of veterans who suffer with chronic pain were willing to try a new approach to their treatment. The fact that five times as many veterans expressed interest in enrolling in WHPO/C than actually enrolled, however, leaves questions as to their degree in readiness to engage in this type of care. Considering the magnitude of the intention to behavior gap, it is important to note that even if all the logistical and social barriers were addressed, an individual veteran's readiness to change may help explain low attendance numbers.

Progression through different stages of change may result in increasing the strength of the veteran's intention to act (Table 2).[6,9] Future projects should evaluate readiness to change and other attitudinal barriers and how this influences engagement. It should be noted, however, that those veterans who did attend the coaching all ranked their satisfaction as ''very high'' and stated that they were more ready to make change now than before the intervention.

Limitations

Given the fact that this was a program evaluation and employed a pragmatic approach, the generalizability of the

Table 2. Transtheoretical Model Constructs

Constructs	*Description*
Stages of change	
Precontemplation	No intention to take action within the next 6 months
Contemplation	Intends to take action with the next 6 months
Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction
Action	Changed overt behavior for less than 6 months
Maintenance	Changed overt behavior for more than 6 months
Termination	No temptation to relapse and 100% confidence

conclusions is limited. Limitations include having a single provider delivering the program, the limited number of days that the program could be delivered, and also the time limitation of the program. In addition, there were limited resources for the project, which did restrict the authors' ability to collect follow-up outcome measures. The authors have attempted to recognize these limitations in their discussion and make recommendations to address these concerns.

In addition, although they have hypothesized that a veteran's readiness to change may play a role in engagement in these types of programs, this project did not specifically utilize a validated measure of readiness to change and, therefore, they cannot make definitive conclusions concerning the etiology of the veteran's willingness to participate. The authors also recognize that the veterans in this project did not self-select to participate in this program; they were specifically contacted and queried about participating. Future projects should attempt to differentiate those veterans who self-select versus those who are recruited.

Recommendations

This small-scale program evaluation identified opportunities to improve implementation of the Whole Health approach for pain management. Whereas previous study has focused on barriers at the organizational level to implementation of the Whole Health approach,[1,4] this program focused on some individual barriers, specifically logistical and social barriers. Addressing the logistical barriers will involve facilities implementing recommendations given in previous study[9,10] such as centralizing Whole Health approaches into one department and allowing for more streamlined scheduling. There is also a need to improve the socialization of the Whole Health approach through local champions and focused marketing to providers and patients.

The more challenging barrier, however, may be the veteran's readiness to change and other attitudinal barriers. This study demonstrated that a substantial number of veterans were interested in engaging in an alternative approach, but very few followed through and attended the sessions. The authors feel that future study should focus on utilizing existing clinical environments (such as primary care) to normalize the Whole Health approach and address personal barriers to changing behavior. In addition, thought should be given to more online resources such as the Whole Health mobile app, designed for veterans to develop a personal health plan. Specific to this project at a rural VA facility, virtual and online applications may be an important resource to enable veterans to access these types of programs.

Future trials may also consider embedding short single patient education sessions about pain within primary care or in conjunction with other commonly utilized treatment modalities such as chiropractic care.[11] In addition, future study may consider the possibility of using online interactive educational programing to address the important issues of readiness to change and engage in alternative strategies for pain management.

In conclusion, addressing chronic pain from a patient-centered perspective may have great promise, but will require future study to understand and address barriers to engagement in those suffering with chronic pain, specifically regarding readiness to actively engage in care.[6]

Authors' Contributions

Paul Dougherty, DC, was the lead on this quality improvement project. He was responsible for oversight of all aspects of the project and contributed to data collection, analysis, and writing of the article. Janet McCarten, PhD, participated in patient recruitment and enrollment, data collection, analysis, and writing of the article. Lisham Ashrafioun, PhD, participated as the consultant psychologist for the project and was involved in data analysis and writing of the article.

Author Disclosure Statement

No competing financial interests exist.

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